Health Insurance Plan
General Information and Cost

Health Insurance Plans	**Insure MT Premier Plan**	**Insure MT Standard Plan**	**Montana State Employee**	**Allegiance Life & Health Insurance Company**
Lifetime Max Benefit	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Deductible	$750 Individual $1,500 Family	$1,5000 individual $3,000 Family	$550 individual $1,650 family	$1,000 individual $2,000 family
Deductible waived for:	In and out of state PPP services, preventive health services (with PPP), well-child care (birth-7), mammograms, hospice, home health, routine newborn services, diabetic education benefit	In and out of state PPP services, preventive health services (with PPP), well-child care (birth-7), mammograms, hospice, home health, routine newborn services, diabetic education benefit	First two non-routine office visits, routine newborn services, preventive adult exams and tests, adult immunizations, allergy shots, child checkups and immunizations	In-network preventive health services, well-child care (birth-7), mammograms, routine newborn services, diabetic education benefit
Coinsurance	Plan pays 75% of allowable fee Member pays 25%	Plan pays 60% of allowable fee Member pays 40%	General 25% Preferred facility services 20% Non-preferred facility services 35%	Plan pays 70% of maximum eligible expense in network and 55% out of network
Out of pocket amount	$2,500 individual $5,000 Family	$3,500 individual $7,000 Family	Average of $2,500 individual Average of $5,000 family	$2,000 individual $4,000 Family
Preventive health Benefit	Paid at 75%.	Paid at 60%.	Paid at 75%.	Paid at 100% for first $250 - deductible and coinsurance apply after that.

Health Insurance Plan
General Information and Cost

Health Insurance Plans	**Insure MT Premier Plan**	**Insure MT Standard Plan**	**Montana State Employee**	**Allegiance Life & Health Insurance Company**
Office visits	First two office visits per member paid at 100%	First two office visits per member paid at 100%		Deductible waived $30 co-pay per visit.
Cost per month	Member $346 Member and spouse $692 Member and family $899		Member $557 Member and spouse $762 Member and children $662 Member and family $776	Cost varies depending on group.

Health Insurance Plan
General Information and Cost

Prescription Drug Plan	**Insure MT Premier and Standard**	**Montana State Employees**	**Allegiance Life & Health Insurance Company**
Deductible	$100 per family member	Retail Pharmacy: $100/member and $300/family Mail order: $0	None
Out-of-pocket max		Per prescription $250 Per member $1,400/yr Per family $2,800/year	
Cost per month	Included in health plan	Included in health plan	Included in health Plan

Dental Plan	**Insure MT Premier and Standard**	**Montana State Employees**	
Deductible		$50/member $150/family	$50 per insured
Out of pocket max	$1000 per member	$1200 per member	Plan pays a maximum benefit per period at $1,500
Cost per month	Included in health plan	Member $31 Member and spouse $47.50 Member and children $46 Member and family $53.20	Varies depending on group.

Health Insurance Plan Summary

Benefit	Insure Montana Standard and Premium Plan	State Employee Plan	Allegiance Life & Health Insurance Company
*Professional Provided Services	Deductible waived for participating providers. Covered services include home and office calls, x-ray, lab, and other services provided by a Professional Participating Provider (PPP).	Office visits 25% (no deductible for first two non-routine visits) Inpatient physician services 25% Lab/ancillary/injectibles/misc. charges 25% Preventive adult exams and tests 25% (no deductible) Adult immunization (such at Pneumonia and Flu) $50 max (no deductible), Allergy shots $50 max (no deductible)	Deductible waived. $30 co-payment for physician office visits for evaluation and management services.
Emergency Services		Ambulance for medical emergency 25% Emergency room 25-35%	Covered under the medical policy – deductible and OOP apply.
*Inpatient Hospital	Room and board, special care units, ancillary charges and transplant coverage	Room charge, ancillary services, surgical services 20-35% Routine newborn care inpatient hospital charges 20-35% (no deductible)	Room and board, special care units, ancillary charges and transplant coverage.
*Outpatient Hospital	Accidental injury, x-ray, and lab, surgery, chemotherapy, respiratory therapy, radiation therapy, medical emergency, surgicenter, and other services	Hospital outpatient and surgical centers 20-35%	Accidental injury, x-ray, and lab, surgery, chemotherapy, respiratory therapy, radiation therapy, medical emergency, surgicenter, and other services

Health Insurance Plan Summary

Benefit	Insure Montana Standard and Premium Plan	State Employee Plan	Allegiance Life & Health Insurance Company
Urgent Care		Facility, professional charges and ancillary lab and diagnostic charges 25%.	Covered under the medical policy – deductible and OOP apply.
*Transplants	$10,000 for ambulance or air transport to site $25,000 for organ procurement per transplant $500,000 for maximum	25%, liver- $200,000, heart- $120,000, lung- $160,000, heart/lung- $160,000, bone marrow- $160,000, pancreas- $68,000, Cornea/kidney- no max	$500,000 life time maximum for all transplant procedures
Skilled Nursing	Skilled nursing facility, transitional care units and extended care facilities. Up to 60 days per benefit period (BP).	25% (20-35% if hospital-based) Max of 70 days/year	Skilled nursing facility, transitional care units and extended care facilities.
Chiropractic Services	$400 maximum per BP. X-ray maximum is $100 per BP	25% (plus charges over $30/visit)	35 visits per benefit period, $25 per visit. $100 X-ray max per benefit period.
Home Health Care	Up to 180 visits per BP, paid at 50%, deductible waived	25% max of 70 days/year	$10,000 allowance per benefit period, max visits 2 per day.
Hospice	Paid at 100%, deductible and coinsurance waived	25% (20-35% if hospital-based), max of 6 months	$10,000 maximum per benefit period.
Individual Therapies	Physical, occupational, speech, and cardiac rehabilitation therapies. $2,000 max per BP. Deductible is waived for PPP services.	Included under Rehab therapy.	Physical, Speech, and Occupational Therapies – max for each $5,000 per benefit period.
Rehabilitation Therapy	$100,000 lifetime max for in-patient and out-patient. Deductible waived for PPP services.	PT, OT, Cardiac, Pulmonary, and Speech included. Inpatient services 20-35% for a max of 60 days/year.	$100,000 lifetime max for inpatient and out-patient therapies.

Health Insurance Plan Summary

Benefit	Insure Montana Standard and Premium Plan	State Employee Plan	Allegiance Life & Health Insurance Company
		Outpatient services 20-35% for a max $2,000/year for all outpatient	
Supplemental Accident	Processed under regular medical benefits.		Deductible waived for the first $500 per accident.
Durable Medical Equipment And Prostheses	Initial purchase, replacements and repair.	25% with max $100 for foot orthotics (per foot)	$15,000 maximum per benefit period for purchase, replacement and repairs. $30,000 max lifetime benefit
Mental Health	Note: Severe MI is processed under regular medical benefits		Severe MI is processed under regular medical benefits
Outpatient MH	Processed under regular medical benefits	20-35% with max 21 days (no max for sever condition)	15 visits per benefit period
Inpatient MH	21 days for professional, hospital and/or freestanding inpatient facility charges, per member, per year.	With EAP counselor referral 25% with max 40 visits/year. Without EAP counselor referral 50% with max 20/visits year.	21 days for professional, hospital and/or freestanding inpatient facility charges, per member, per year.
Chemical Dependency	$6,000 per 12 months for inpatient and outpatient services. $12,000 lifetime maximum for inpatient services $2,000 inpatient and outpatient benefit available per benefit year after the $12,000 max is met	Inpatient service 20-35%, outpatient with EAP counselor referral 25% and 40 visit limit, outpatient with no EAP counselor referral 50% and 20 visit limit. Max combined inpatient and outpatient is $6,000/year; $12,00 lifetime;	$6,000 per 12 months for inpatient and outpatient services. $12,000 lifetime maximum for inpatient services. $2,000 inpatient and outpatient benefit available per benefit year after the $12,000 max is met

Health Insurance Plan Summary

Benefit	Insure Montana Standard and Premium Plan	State Employee Plan	Allegiance Life & Health Insurance Company
		$2,000/year after max is met	
*Well-Child Care	Exams (at 1, 2, 4, 6, 9, 15, 18 and 24 months) lab tests and routine immunizations from birth through 7. Deductible does not apply. Paid at 60% of the allowable fee.	25% (no deductible) and 0% (no deductible) for County health Dept. through age 7)	Deductible waived. Birth through 2 – max 12 visits 3 through 7 – 1 visit per benefit period
*Mammograms	Paid at the actual charge or $70, whichever is less, for each covered mammogram. Deductible and coinsurance apply after the first $70 is paid.	25% (no deductible)	$70 per mammogram. Deductible does not apply. Any remaining charges can apply to any preventative "bucket" selected.
Diabetic Education Benefit	Up to $250 per benefit period for outpatient services. Deductible does not apply.	20-35% with max $250 per year	Up To $250 per benefit period for outpatient services. Deductible does not apply.
*Prescription Drugs	$200 deductible per family member, then: Retail purchase 34-day supply: $10 generic, $30 formulary, $75 brand name, Mail-order purchase 90-day supply: $20 generic, $60 formulary, $150 brand name	Retail purchase 30-day supply: generic 10% coinsurance ($10 minimum), formulary 20% coinsurance ($25 minimum), brand name 40% coinsurance ($40 minimum). Mail-order purchase 90-day: generic $20 copay + 10% of cost over $400, formulary $20 copay + 20% of cost over $400, brand name $60 copay + 40% of cost over $400	$10 co-pay on Generics $30 co-pay on Preferred Brand $60 - on Non-preffered Mail order co-pay – 2x retail co-pay
*Dental Plan	Preventive and diagnostic 100% Fillings/oral surgery 80% up to	Preventive and Diagnostic 100%	Preventative and Diagnostic 100%, Fillings/oral surgery at

Health Insurance Plan Summary

Benefit	Insure Montana Standard and Premium Plan	State Employee Plan	Allegiance Life & Health Insurance Company
	max of $1,000	Fillings, oral surgery, etc. 80% Dentures, Bridges, etc. 50 % Max yearly benefit for B and C of $1,200	80%. Annual maximum benefit of $1,500

ALLEGIANCE
LIFE & HEALTH INSURANCE COMPANY

GROUP HEALTH INSURANCE OUTLINE OF COVERAGE

Here is a summary of benefits provided under the Allegiance Life & Health (**AL&H**) Group Health Insurance Policy. Your Benefits Guide, any applicable endorsements and the following schedule of benefits describe the benefits and coverage provided under the Group Basic Health Insurance Policy.

You are responsible for paying:

- Deductible.
- Expenses up to the Out-of-Pocket Maximum amount and any amount over the Maximum Eligible Expense (**MEE**).
- Amounts that exceed benefit limitations, including the lifetime Maximum benefit for all causes.
- Costs for all non-covered services.
- Amounts that exceed the allowed charges for out-of-network providers (Non-PPO), except in certain circumstances (such as emergency care).

In-Network Providers (PPO): AL&H has a strong network of physicians and specialists across the state of Montana, as well as nationally.

To find out if your provider is in our network, check our online look-up at:
www.allegiancelifeandhealth.com
or contact our customer service department at
1-800-737-3137

Out-of-Network Providers (Non-PPO): Out-of-network providers have not contracted directly with AL&H. Out-of-network providers can bill you the difference between the allowable fee and their total charge, plus any deductible and co-payment, making your out-of-pocket cost potentially higher.

COST SHARING PROVISIONS

The Cost Sharing Provisions are only a summary. All other Policy maximums, limits and exclusions apply.

Benefit Description	PPO	Non-PPO
Deductible per Insured. **PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible.**	$1,000	Same as PPO.
Deductible per covered family. **PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible.**	2x the deductible per Insured.	Same as PPO.
Out-of-Pocket Maximum. **PPO Out-of-Pocket Maximum does not apply toward Non-PPO Out-of-Pocket Maximum. Non-PPO Out-of-Pocket Maximum does not apply toward PPO Out-of-Pocket Maximum.**	$1,500	Same as PPO.
Out-of-Pocket Maximum per covered family. **PPO Out-of-Pocket Maximum does not apply toward Non-PPO Out-of-Pocket Maximum. Non-PPO Out-of-Pocket Maximum does not apply toward PPO Out-of-Pocket Maximum.**	2x the Out-of-Pocket Maximum per Insured.	Same as PPO.
Lifetime Maximum for all causes.	$2,000,000	Combined with PPO Lifetime Maximum

<table>
<tr><th>Benefit Description</th><th>PPO</th><th>Non-PPO</th></tr>
<tr><td>Co-pay for physician office visit.

The Co-payment applies only to those charges for evaluation and management that are performed in an office by the Provider. The Office Visit Benefit does not apply to charges for Lab, X-ray and diagnostic testing. These services are subject to the Annual Deductible and Benefit Percentage.</td><td>$30 – available with all other Benefit Percentage options. Deductible does not apply.</td><td>No co-pay available. Deductible and Benefit Percentage apply.</td></tr>
<tr><td>Benefit Percentage of the Maximum Eligible Expense (“MEE”) that the Policy pays. It pays for covered services after the deductible. It pays the percentage selected up to the out-of-pocket maximum. Then it pays 100% of covered charges.</td><td>70%</td><td>55% (for the 70% PPO Option).</td></tr>
<tr><td>Optional preventive services (see “Preventive Care” in the section titled “Limited Medical Benefits”).</td><td>100% of MEE of the first $250 Deductible is waived.</td><td>Subject to Deductible and Benefit Percentage</td></tr>
<tr><td>Endorsement A: Dental Benefits</td><td>Selected
<table><tr><td>Deductible</td><td>$50</td></tr><tr><td>Type A Services %</td><td>100%</td></tr><tr><td>A Deductible Waiver</td><td>No</td></tr><tr><td>Type B Services %</td><td>80%</td></tr><tr><td>Type C Services %</td><td>50%</td></tr><tr><td>Annual Maximum</td><td>$1,500</td></tr><tr><td>Orthodontia</td><td>None</td></tr><tr><td>Deductible Credit</td><td>No</td></tr></table></td><td></td></tr>
<tr><td>Endorsement B: Vision Benefits</td><td>☐ Selected
☐ Not Selected</td><td></td></tr>
<tr><td>Endorsement C: Supplemental Accidental Injury Benefit</td><td>Selected
The Policy pays 100% of MEE of the first $500</td><td></td></tr>
</table>

Prescription Drug Coverage: ***Specialty Prescriptions*** [for discount card]***:*** ***Policy*** pays applicable ***Benefit Percentage*** after satisfaction of the ***Deductible.*** ***Specialty Prescriptions*** [for co-pay options]***:*** ***Insured*** pays a 20% co-pay not subject to ***Deductible***. ***Insured*** co-payments toward ***Specialty Prescriptions*** do not count toward satisfying ***Deductible*** or the ***Out-of-Pocket Maximum.*** [For HSA Compatible Plans, only the discount card is available.]	***Insured*** pays $10 co-pay on covered generic drugs; $30 co-pay on covered preferred brand drugs; and $60 co-pay on covered non-preferred brand drugs. Mail order co-pay = 2x retail co-pay.	Reimbursement limited to ***MEE.*** **NOTE: *Specialty Prescriptions* are a benefit only when obtained through *Our* contracted *Specialty Pharmacy.***
Prescription Drug Deductible per ***Insured***:	None.	Same as PPO.

The *Insured* is responsible for payment of charges that exceed the *Policy's* benefits. If you use a Non-PPO Provider:

1. **The amount You must pay will increase; and**
2. **You will be responsible for any amount over the *MEE*.**

MONTHLY PREMIUMS

☐ Employee only	$_____
☐ Employee & Spouse	$_____
☐ Employee & Children	$_____
☐ Employee, Spouse & Child	$_____
☐ Employee, Spouse & Children	$_____

Premiums are based on:

1. The benefit options selected.
2. The health care trend rate.
3. The location of the enrollees.
4. The ***Employer's*** industry classification; and
5. The risk characteristics of the ***Employer.***

Renewal rates will not exceed maximums under State law.

ALL BENEFITS UNDER THIS ***POLICY*** ARE SUBJECT TO THE APPLICABLE ***POLICY*** EXCLUSIONS. ALL BENEFITS ARE ALSO SUBJECT TO THE ***MEE.***

ELIGIBLE ***INSUREDS*** ARE ***EMPLOYEES*** OF THE ***EMPLOYER. YOU*** MAY ENROLL ***YOUR*** ELIGIBLE ***DEPENDENTS.*** TO BECOME COVERED, ***DEPENDENTS*** MUST HAVE BEEN SUCCESSFULLY ENROLLED UNDER THIS ***POLICY.***

Unless otherwise indicated in this *Policy*, the *Deductible* and *Benefit Percentage* above apply to all benefits.

MAXIMUMS AND LIMITATIONS:

See also the section on Limited Medical Benefits. That section contains a more complete explanation of the covered services listed below.

ALCOHOLISM, AND / OR CHEMICAL DEPENDENCY
- Maximum Benefit per Lifetime $12,000
- Maximum Benefit per 12 consecutive-month period $6,000
- Annual Benefit after Maximum Benefit per Lifetime is met $2,000

CHIROPRACTIC CARE
- Maximum Number of Treatments per ***Benefit Period*** 35
- Maximum Benefit per Treatment $25
- Maximum Benefit for Diagnostic X-rays per ***Benefit Period*** $100

"Treatment" includes all services provided during a calendar day, except for X-rays.

DIABETIC EDUCATION BENEFIT

Outpatient Expenses
- Maximum Benefit per ***Benefit Period*** $250

"Outpatient Expenses" means any outpatient self-management training and education for the treatment of diabetes. Such training and education must be provided by a ***Provider*** with expertise in diabetes.

HOME HEALTH CARE
- Maximum Number of Visits per Day 2
- Maximum Allowance per Visit $50
- Maximum Allowance per ***Benefit Period*** $10,000
- Maximum Benefit per Lifetime $20,000

HOSPITAL LIMITATIONS
- ***Hospital Room and Board*** Limitation ..... Average ***Semi-private***
- ***Intensive Care Unit*** Limitation ..... ***MEE***

SEVERE MENTAL ILLNESS

Benefits for ***Severe Mental Illness*** are paid the same as any other medical condition. They will not be subject to any annual or lifetime limits for ***Mental Illness.***

MENTAL ILLNESS
- Maximum Number of ***Outpatient*** visits per ***Benefit Period*** 15
- Maximum Benefit for ***Outpatient*** visits after ***Deductible*** will not be less than $2,000
- Maximum ***Inpatient*** Benefit per ***Benefit Period*** ..... 21 Days

Partial hospitalization is covered on a two (2) for one (1) basis. Two days of partial hospitalization equals one day of ***Inpatient*** care. ***Inpatient*** maximum applies.

MAMMOGRAMS

Deductible Waived, ***Benefit Percentage*** 100%
Maximum Benefit per mammogram $70

PREVENTIVE CARE

Routine ***Outpatient*** Well-child Care (birth through 7 years of age).
Deductible Waived, ***Benefit Percentage*** 100%
Maximum Number of Visits through 2 years of age 12
Visits age 3 through age 7 are limited to 1 visit per ***Benefit Period*** or as recommended by Montana law and the U.S Department of Health and Human Services.

Routine Prostate Specific Antigen (PSA) Test
Deductible Waived, ***Benefit Percentage*** 100%
Maximum Benefit per ***Benefit Period*** $70

Routine Office Visit ..... See Cost Sharing Provisions.

ORTHOTIC SUPPLY

Maximum Benefit Per ***Benefit Period*** $350
Maximum Benefit per Lifetime $700

DURABLE MEDICAL EQUIPMENT ("DME")

Maximum Benefit per ***Benefit Period*** $15,000
Maximum Benefit per Lifetime $30,000

PROSTHETIC APPLIANCE

Maximum Benefit per ***Benefit Period*** $15,000
Maximum Benefit per Lifetime $30,000

REHABILITATION THERAPY (Includes Inpatient and Outpatient Expenses)
Maximum Combined Lifetime Benefit for all Rehabilitation Therapy $100,000

Physical Therapy
Maximum Benefit per ***Benefit Period*** $5,000

Speech Therapy
Maximum Benefit per ***Benefit Period*** $5,000

Occupational Therapy
Maximum Benefit per ***Benefit Period*** $5,000

HOSPICE CARE

Maximum Benefit per ***Benefit Period*** $10,000
Maximum Benefit per Lifetime $20,000

ORGAN AND TISSUE TRANSPLANT SERVICES

Deductible applies, ***Benefit Percentage*** ..... Applies

Maximum Benefit for each Procedure

Liver Transplant	$170,000
Heart Transplant	$145,000
Kidney Transplant	$60,000
Simultaneous Kidney / Pancreas Transplant	$100,000
Pancreas Transplant	$90,000
Lung Transplant	$140,000
Heart / Lung	$175,000
Allogenic Stem Cell (related)	$135,000
Allogenic Stem Cell (unrelated)	$215,000
Autologous Stem Cell	$90,000
Other Eligible Transplant or Replacement Procedure	$50,000

Maximum Aggregate Benefit per Lifetime (All Transplant Procedures) $500,000
(subject to the ***Lifetime Maximum*** for all Causes)

Maximums and limits apply to all expenses in connection with any eligible organ or tissue transplant. See also the Major Organ / Tissue Transplant Benefit.

The ***Claims Processor*** has contracts with various medical centers. These medical centers specialize in transplant procedures. The contracts provide for discounts for transplant costs. The discounted cost is approximately equivalent to the maximum benefits stated above. The ***Claims Processor*** will provide a list of contracted facilities upon request. The ***Claims Processor*** will also assist with admission.

OTHER LIMITATIONS

Surgery and any complications for the following are covered:

A. Blepharoplasty.
B. Abdominoplasty.
C. Mammoplasty (if unrelated to reconstructive breast surgery).
D. Brow Ptosis (Brow lifts).

Maximum Benefit per Lifetime for all covered services $1,000

NOTICE: This is a Claims Made Medical Reimbursement Policy. Coverage is limited to covered expenses incurred and submitted to ***Us*** while this ***Policy*** is in force. Please review the ***Policy*** carefully. Please discuss the coverage with ***Your*** insurance advisor. All application forms submitted to ***Us*** are made a part of this ***Policy***. The ***Employer*** may obtain a copy of all application forms by written request to ***Us***.